DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

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MEMORANDUM FOR DISTRIBUTION C

FROM: AF/SG

SUBJECT: Air Force Guidance Memo to AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

This is an AF Guidance Memorandum immediately changing AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program.* Compliance with this Memorandum is mandatory. To the extend its directions are inconsistent with other Air Force publications, the information herein prevails, in accordance with AFI 33-360, *Publications and Forms Management.*

The changes set forth in this Guidance Memorandum are effective immediately:

Addition of para 3.5.6. In order to ensure military readiness; safeguard the health and wellness of the force; and maintain good order and discipline in the service, the knowing use of any intoxicating substance, other than the lawful use of alcohol or tobacco products, that is inhaled, injected, consumed, or introduced into the body in any manner to alter mood or function is prohibited. These substances include, but are not limited to, controlled substance analogues (e.g., designer drugs such as "spice" that are not otherwise controlled substances); inhalants, propellants, solvents, household chemicals, and other substances used for "huffing"; prescription or over-the-counter medications when used in a manner contrary to their intended medical purpose or in excess of the prescribed dosage; and naturally occurring intoxicating substances (e.g., Salvia divinorum). The possession of any intoxicating substance described in this paragraph, if done with the intent to use in a manner that would alter mood or function, is also prohibited. Failure to comply with the prohibitions contained in this paragraph is a violation of Article 92, UCMJ.

The guidance in this Memorandum becomes void after 180 days have elapsed from the date of this Memorandum, or upon release of an AF publication incorporating AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program,* whichever is earlier.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

cc: ALMAJCOM/SG

BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-121

26 SEPTEMBER 2001

Certified Current 2 April 2010

Incorporating Change 5, 22 April 2010

Medical

ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available for downloading or ordering on the e-Publishing website at **http://www.e-Publishing.af.mil.**

RELEASABILITY: There are no releasability restrictions on this publication.

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Supersedes: AFI44-121, 1 January 2001

Certified by: AF/SG3
(Maj Gen Thomas J. Loftus)
Pages: 38

This Air Force Instruction (AFI) establishes guidance for the Air Force Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program. It implements Air Force Policy Directive (AFPD) 44-1. This instruction provides guidance for the identification, treatment and management of personnel with substance abuse problems and describes Air Force policy regarding alcohol and drug abuse. This instruction applies to all active duty Air Force members, and to members of the Air Force Reserve Command (AFRC) and Air National Guard (ANG) when activated longer than 30 days. The AFRC and ANG does not provide treatment to substance abusers. The AFRC and ANG will establish policies and procedures for the appropriate management of ANG and AFRC personnel with potential substance abuse problems.

The Privacy Act of 1974 applies to this instruction. Each form that is subject to the provisions of AFI 37-132 *"Air Force Privacy Act Program"* must contain a Privacy Act Statement, either in the form itself or attached to it. The authorities to collect personal information and maintain the records listed in this instruction are Title 10, United States Code (U.S.C.) 8013, 42 U .S.C.290 dd 2, et seq., and Executive Orders 9397 and 11478. System of Records Notice F030 AF MP B, *Drug/Alcohol Abuse Assessment and Rehabilitation Case Files*, applies. **Attachment 1** contains a glossary of references, abbreviations, acronyms, and terms. Send comments and suggested improvements on AF Form 847, Recommendation for Change of Publication through channels to AFMOA/SGOC 110 Luke Avenue, Room 400, Bolling AFB, Washington, D.C. 20332-7050.

SUMMARY OF CHANGES

This interim change updates the OPR/certifying official, updates the address and office symbol of the ADAPT branch, implements the use of Alcohol Brief Counseling (ABC) in place of the 6-hour Substance Abuse Awareness Seminar (SAAS), provides new guidance that clarifies requirements for the assessment and treatment of civilian employees, provides a consent for release of patient information for civilian employees seen in ADAPT, updates guidance on the clinical practice of Certified Alcohol and Drug Abuse Counselors (CADAC), deletes the out-of-date list of active duty Substance Abuse Recovery Centers, and implements the use of AF Form 469 for reporting duty limiting conditions as required by AFI 10-203, *Duty Limiting Conditions*, 25 Oct 2007. This IC applies to all active duty Air Force members, members of the Air Force Reserve Command, and Air National Guard members on Active Guard Reserve status, Title 32 status, or on the Personnel Reliability Program. A margin bar indicates newly revised material.

This Air Force Instruction (AFI) establishes guidance for the Air Force Alcohol & Drug Abuse Prevention & Treatment (ADAPT) Program. It implements Air Force Policy Directive (AFPD) 44-1. This instruction provides guidance for the identification, treatment and management of personnel with substance abuse problems and describes Air Force policy regarding alcohol and drug abuse. This instruction applies to all active duty Air Force members, members of the Air Force Reserve Command (AFRC), and Air National Guard (ANG) members on Active Guard Reserve status, Title 32 status, or on the Personnel Reliability Program. ANG will comply with AFI 44-121. The Privacy Act of 1974 applies to this instruction. Each form that is subject to the provisions of AFI 37-132 "Air Force Privacy Act Program" must contain a Privacy Act Statement, either in the form itself or attached to it. The authority to collect personal information and maintain the records listed in this instruction are Title 10, United States Code (U.S.C.) 8013, 42 U.S.C. 290 dd 2, et seq., and Executive Orders 9397 and 11478. System of Records Notice F030 AF MP B, Drug/Alcohol Abuse Assessment and Rehabilitation Case Files, applies. Attachment 1 contains a glossary of references, abbreviations, acronyms, and terms. Send comments and suggested improvements on AF Form 847, Recommendation for Change of Publication through channels to AFMOA/SGHW, 2216 Hughes Ave, Ste 153, Lackland AFB, TX 78235-9852.

Chapter 1

RESPONSIBILITIES

Section 1A—Office of the Surgeon General

1.1. Air Force Surgeon General (HQ USAF/SG). HQ USAF/SG overseas policy and implementation of the Alcohol and Drug Abuse Prevention & Treatment (ADAPT) Program.

1.2. Air Force Medical Operations Agency, (AFMOA) Mental Health Division (SGHW), ADAPT/DDR Branch:

1.2.1. Develops, implements, and manages the ADAPT program operations to support established policies.

1.2.2. Manages programming and execution of Air Force Substance Abuse and Demand Reduction Program budgets.

1.2.3. Coordinates with other Air Staff agencies involved in ADAPT programs.

1.2.4. Communicates with other Air Force, DoD, and civilian agencies that have collateral ADAPT responsibilities and interests.

1.2.5. Provides policy and operational guidance and clarification to MAJCOMs.

1.2.6. Convenes and attends conferences and other professional forums that address ADAPT issues and determines appropriate Air Force representation at these events.

1.2.7. Assists the mental health enlisted career field manager with manpower and personnel issues.

1.2.8. Responds to ADAPT related complaints, AF suggestions, Congressional and high-level inquiries, and Freedom of Information Act requests.

1.2.9. Serves as OPR for the Demand Reduction Program (DRP).

1.2.10. Serves as Office of Collateral Responsibility (OCR) on deterrence, interdiction, anti-smuggling, and intelligence activities.

1.2.11. Monitors the Drug & Alcohol Counselor Certification Program, in coordination with HQ AETC/SG.

1.2.12. Develops procedures for managing and documenting ADAPT activities.

1.2.13. Develops and prepares ADAPT statistical data and reports for program management and policy development. This requirement is exempt from RCS reporting requirements IAW AFI 37-124, para 2.11.12.

1.2.14. Collects data for the ADAPT program and prepares management reports.

1.2.15. Reviews inspection reports and other assessments.

Section 1B—Headquarters, US Air Force

1.3. Judge Advocate General of the Air Force (HQ USAF/JA). HQ USAF/JA provides legal opinions, instructions, guidance, and assistance regarding ADAPT programs and policies.

1.4. Air Force Director of Security Forces (HQ USAF/SF).

1.4.1. Develops policies and procedures for security forces who may be involved in detection, enforcement, and investigation of substance abuse.

1.4.2. Coordinates with other military services and federal or local investigative and law enforcement agencies on substance abuse matters listed in **paragraph 1.4.1** for which security forces are responsible.

1.4.3. Develops policies and procedures for granting access to classified information, unescorted entry, and clearances. These policies cover, among other things, cases where a member's clearance eligibility, trustworthiness, and reliability are called into question by improper use or abuse of drugs or alcohol.

Section 1C—Major Commands (MAJCOM)

1.5. AJCOM/FOA/DRU/SG.

1.5.1. Implements, coordinates, evaluates and reports Air Force ADAPT policies and programs at the MAJCOM/FOA/DRU level.

1.5.2. Appoints an ADAPT Program Manager, who:

1.5.2.1. Identifies problem areas through trend analysis and takes corrective actions for problems that cannot be solved at the installation level.

1.5.2.2. Ensures development of prevention programs that specifically target high risk groups, encourage responsible behavior, and enhance organizational wellness.

1.5.2.3. Ensures installation mental health technicians working in ADAPT receive on-going, formal training and guidance, and are certified IAW Air Force policy.

1.5.2.4. Determines the necessity for special assistance and training. This includes acting as liaison for continuing education quotas and all other training required or requested by installation offices. Determines and requests MAJCOM requirements for training according to AFCAT 36-2223, *US Air force Formal Schools*.

1.5.2.5. Provides ADAPT guidance to geographically separated units on programs and policy.

1.5.2.6. Responds to substance abuse related complaints, AF suggestions, and Congressional and higher level inquiries.

1.5.2.7. Provides assistance and guidance to base-level mental health offices regarding ADAPT issues.

1.5.2.8. Develops MAJCOM unique ADAPT programs and procedures as appropriate.

1.5.2.9. In addition, HQ AETC/SG will:

1.5.2.9.1. Manage all aspects of the Substance Abuse Counselor Certification Program.

1.5.2.9.2. Ensure mental health technician training programs include appropriate topics.

1.5.2.9.3. Develop, review, and update ADAPT educational curricula, objectives, materials, and programs.

Section 1D—Installation

1.6. Installation Commander.

1.6.1. Ensures ADAPT programs are developed and implemented.

1.6.2. Ensures allocation of adequate space for provision of substance abuse classroom education and services.

1.6.3. Ensures ADAPT Program receives adequate funding to support counseling, treatment, prevention and outreach efforts. Since non-clinical prevention, education, and aftercare are not funded through the Defense Health Program (DHP), resources will be provided by the "line" to support these programs.

1.6.4. Ensures available funding in PE 88723 (Substance Abuse Program) for continuing education and training for certified substance abuse counselors to meet requirements of International Certification Reciprocity Consortium (ICRC). (The ICRC requires that Certified Substance Abuse Counselors attain a minimum of 60 continuing education hours every three years in order to maintain their certification).

1.7. MTF Commander:

1.7.1. Serves as the OPR for substance abuse issues.

1.7.2. Appoints, in writing, a privileged mental health provider as ADAPT Program Manager, who is knowledgeable in substance abuse and addictions prevention, assessment, intervention, and treatment.

1.7.3. Ensures outpatient, partial hospitalization, and inpatient services meet current quality assurance standards and complies with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for alcohol and drug abuse treatment facilities.

1.7.4. Ensures medical personnel receive on-going training in the identification of substance abuse problems, and ensures all cases of suspected or diagnosed substance abuse are referred to mental health for assessment.

1.7.5. Ensures substance abuse assessments are conducted on a priority basis IAW **Chapter 3** of this instruction.

1.7.6. Provides or arranges for medical assessment, detoxification, residential, and non-residential treatment for substance abusers, including patient and family psychoeducational programs at substance abuse recovery centers.

1.7.7. Provides or arranges for aeromedical evacuation of members in in-patient status for substance abuse, and family members attending family treatment programs.

1.7.8. Ensures all licensed health care providers, working in direct patient care, managerial, or supervisory roles over drug and alcohol abuse personnel receive additional training in chemical dependency.

1.8. ADAPT Program Manager (ADAPTPM).

1.8.1. Manages local ADAPT programs in accordance with current policies and guidance.

1.8.2. Coordinates on-base resources to provide effective prevention, education, identification, assessment, and treatment programs. On-base services should include early intervention (Level 0.5) and outpatient programs (Level I) as defined in the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders. Limited Scope Medical Treatment Facilities with insufficient mental health personnel or inadequate patient census to support the full range of ADAPT services will ensure individuals requiring these services are referred to an appropriate ADAPT program or civilian treatment facility.

1.8.3. Coordinates funding requirements using Program Element (PE) 88723 through the wing budgeting cycle. A Resource Center Cost Center (RCCC) should be established within the MTF to capture funds in PE 88723. This allows substance abuse funds to be managed by the MTF resource advisor (RA) with assistance of the Wing RA.

1.8.3.1. Defense Health Program (DHP) dollars may be used to support initial substance abuse assessment, and clinical treatment services. Clinical treatment includes services provided to patients receiving a medical diagnosis of alcohol abuse or dependence, such as out-patient treatment, partial hospitalization, or in-patient treatment programs.

1.8.3.2. Prevention, awareness education, and non-clinical intervention (services provided to patients not receiving diagnosis of abuse or dependence) will be paid for out of PE 88723 (line) funds.

1.8.3.3. ADAPTPMs will ensure that substance abuse workload reporting is completed using Medical Expenses Performance Report Services (MEPRS) codes AFBA (In-Patient Substance Abuse Treatment) and BFFA (Ambulatory Care - Substance Abuse Clinic). Since substance abuse authorizations are funded through the line, Substance Abuse personnel will account for Full Time Equivalent (FTE) Work Month, and workload, IAW DoD 6010.13M.

1.8.4. Coordinates with off-base resources to effectively supplement the base alcohol and drug abuse prevention and treatment programs.

1.8.5. Ensures development and implementation of ADAPT education programs.

1.8.6. Meets regularly with Demand Reduction Program Manager, Family Advocacy, Health and Wellness Center and Family Support Center managers, to coordinate community-based health, wellness, and prevention services.

1.8.7. Serves as an active member of the Wing Health Promotion Working Group and/or Integrated Delivery System (IDS).

1.8.8. Assists commanders and supervisors to identify and refer individuals needing ADAPT services.

1.8.9. Ensures that all care and services provided by non-privileged personnel are supervised IAW AFI 44-119 and other applicable Air Force Policy.

1.8.10. Proposes written wing or installation policy concerning alcohol and drug abuse prevention and treatment.

1.8.11. Ensures continuous quality improvements in the ADAPT program by developing and tracking metrics related to alcohol and drug abuse prevention and treatment.

1.8.12. Provides managerial guidance and clinical supervision to the ADAPT staff.

1.8.13. Helps geographically separated units, and personnel, with ADAPT related issues as outlined in the local host-tenant agreement or memoranda of understanding.

1.8.14. Ensures ADAPT personnel are trained and certified or actively participating in the certification process.

1.8.14.1. Eligibility for certification. Air Force personnel and volunteers who are currently performing duties related to ADAPT are eligible to apply for certification if they meet the standards outlined in the Air Force Substance Abuse Counselor Certification Handbook.

1.8.14.2. Maintaining Certification. Individuals certified through the Air Force Substance Abuse Counselor Certification Board will maintain their certification as long as they provide services in support of the ADAPT program. Requirements for counselor recertification are outlined in the Air Force Substance Abuse Counselor Certification Handbook.

1.8.15. Markets ADAPT programs to senior leadership on the installation and to the base population.

1.8.16. Provides input to the Family Support Center (FSC) in the development of community referral guidelines and the Integrated Delivery System (IDS) as outlined in the IDS implementation guidance.

1.9. Chief of Security Forces: Provides the base ADAPT program personnel "*For Official Use Only*" access to:

1.9.1. AF Forms 110, *Individual Incident Reference.*

1.9.2. DD Forms 1569, *Incident Complaint Record.*

1.9.3. AF Forms 53, *Security Police Blotter.*

1.10. Geographically Separated Unit (GSU) Commanders. GSU commanders will refer individuals to the nearest ADAPT program for assessment when substance use is suspected to be a contributing factor in an incident or when an individual is suspected of having a problem with alcohol or other drugs (also see paragraph 3.8. Commander's Identification and Associated Roles and Responsibilities).

1.10.1. Support for requested prevention services will be provided by the host installation ADAPT program.

1.10.2. Treatment of substance abuse problems for patients assigned to GSUs may include services through local (civilian) resources with on-going case-management provided through the ADAPTPM at the nearest MTF.

1.11. Air National Guard (ANG) Commanders. ANG commanders will refer Drill Status Guardsmen suspected of substance abuse to their civilian provider for assessment and referral for treatment IAW DoD 5210.42-R and AFMAN 10-3902 Chapter 5. The civilian provider must be a licensed mental health professional or a certified substance abuse counselor.

1.11.1. The host installation ADAPTPM will provide on-going case-management and final review of treatment. The ADAPTPM will make recommendations of PRP status to the PRP Competent Medical Authority or return to flight status to the flight surgeon.

Chapter 2

MENTAL HEALTH RECORDS FOR ADAPT PROGRAM PARTICIPANTS

2.1. Objective. Establish policy on documentation.

2.2. Managing Records.

2.2.1. Mental Health records on ADAPT patients will thoroughly reflect findings during the initial assessment, intake and patient orientation, diagnosis, treatment plan, course of treatment, referrals, case management activities, progress reviews and status upon termination.

2.2.2. Providers shall annotate initial diagnosis and treatment plan; and changes in status, medications, or the treatment plan in progress notes in the patient's medical record.

2.2.3. Case notes will be documented in the standard SOAP format.

2.2.4. Records pertaining to substance abuse are a part of the patient's mental health record which are to be kept at the Mental Health Clinic for two years after treatment ceases before being retired to the NPRC.

2.2.4.1. AFMAN 37-139, *"Records Disposition Schedule*," provides guidance regarding records retention and disposition.

2.2.4.2. Records of substance abuse case files closed before 1 October 1994 will be maintained separately and be destroyed on 1 October 1997 except that all 1982-83 drug case files will be maintained until 30 September 1999 and then be destroyed.

2.2.5. When patients depart PCS and are still receiving ADAPT treatment or aftercare services, a copy of the patient's mental health record will be forwarded to the gaining installation ADAPT program office to ensure continuity of care is provided.

Chapter 3

AIR FORCE ALCOHOL & DRUG ABUSE PREVENTION & TREATMENT (ADAPT) PROGRAM

Section 3A—General Information

3.1. Program Objective. The primary objective of the ADAPT Program is to promote readiness and health and wellness through the prevention and treatment of substance abuse; to minimize the negative consequences of substance abuse to the individual, family, and organization; to provide comprehensive education and treatment to individuals who experience problems attributed to substance abuse; return identified substance abusers to unrestricted duty status or to assist them in their transition to civilian life, as appropriate.

3.2. Scope and Limitations.

3.2.1. Records of substance abuse case files collected and maintained as a part of ADAPT treatment or aftercare services are maintained in accordance with 42 U.S.C. 290dd-2. These records are protected from public disclosure, and are released only under the circumstances listed in 42 U.S.C. 290dd-2(b) and (c).

3.2.2. ADAPT records may be disclosed or released to other offices or agencies within the Armed Forces. These records are not protected from use within the Armed Forces. ADAPT records may also be released or disclosed to components of the Department of Veteran's Affairs furnishing health care to veterans.

3.2.3. ADAPT records may be disclosed to appropriate authorities to the extent necessary to comply with State or local child abuse and child neglect reporting requirements.

3.2.4. Active Duty members, dependents, and retirees are eligible for counseling and treatment, following TRICARE guidelines for access. Eligible beneficiaries shall receive substance abuse services as authorized through their selected health care option: TRICARE Prime, TRICARE Extra, or TRI- CARE Standard.

3.3. Alcohol Abuse. The Air Force policy recognizes that alcohol abuse negatively affects public behavior, duty performance, and/or physical and mental health. The Air Force provides comprehensive clinical assistance to eligible beneficiaries seeking help for an alcohol problem.

3.4. Alcohol Deglamorization. AFI 34-119, *Alcohol Beverage Program,* outlines alcohol deglamorization programs and policies in the Air Force.

3.5. Illicit Drug Use. The Air Force does not tolerate the illegal or improper use of drugs by Air Force personnel. Such use:

3.5.1. Is a serious breach of discipline.

3.5.2. Is not compatible with service in the Air Force.

3.5.3. Automatically places the member's continued service in jeopardy.

3.5.4. Can lead to criminal prosecution resulting in a punitive discharge or administrative actions, including separation or discharge under other than honorable conditions.

3.5.5. Studies have shown that products made with hemp seed and hemp seed oil may contain varying levels of tetrahydrocannabinol (THC), an active ingredient of marijuana which is detectable under the Air Force Drug Testing Program. In order to ensure military readiness, the ingestion of products containing or products derived from hemp seed or hemp seed oil is prohibited. Failure to comply with the prohibition on the ingestion of products containing or products derived from hemp seed or hemp seed oil is a violation of Article 92, UCMJ.

Section 3B—Prevention and Education

3.6. Substance Abuse Prevention Strategies: Substance abuse prevention strategies must be comprehensively structured to reduce individual and organizational risk factors and to increase resiliency factors in high-risk populations.

3.6.1. Substance abuse prevention at the installation level is a collaborative effort shared among various agencies to include the mental health (ADAPT), drug demand reduction, and health promotions.

3.6.1.1. The Integrated Delivery System (IDS) will be the focal point for the development and implementation of programs geared towards increasing organizational and individual awareness of substance abuse issues, trends, and threat to mission readiness.

3.6.1.2. The IDS will ensure that health care providers, commanders, first sergeants, and supervisors understand the impact of substance abuse on the mission, how to identify the warning signs of substance abuse, and the referral process.

3.6.2. Demand reduction program (DRP) activities are limited to those directly related to illegal and illicit drug abuse prevention.

3.6.3. Substance abuse prevention and education programs will at a minimum meet the objectives listed in **Table 3.1** of this AFI, DoD Directive 1010.5 “Education and Training in Alcohol Drug Abuse Prevention,” DoD Directive 1010.4 “Alcohol and Drug Abuse by DoD personnel,” DoD Directive 1010.7 “Drunk and Drugged Driving by DoD Personnel,” DoD Directive 1010.6 “Rehabilitation and Referral Services for Alcohol and Drug Abusers,” DoD Directive 1010.14 “Prevention, Early Identification and Treatment of Alcohol and Other Drug Impairment on DoD Health Care Providers,” and be tailored to meet the specific needs of the organization.

3.6.3.1. All individuals referred to the ADAPT program who have had an Alcohol Related Misconduct (ARM) incident will be required to receive the following targeted prevention education:

3.6.3.1.1. Brief Consultation and Feedback/Alcohol Brief Counseling (ABC): This will follow the intake assessment and should last a minimum of 30 minutes. It can completed on the same day as the assessment and coded as an additional intervention or at an additional appointment. The process includes review of the SUAT Patient Feedback and other pertinent assessment results. The next step is the development of the personalized Change Plan. Clinics can decide if this should be initiated on the same day as the assessment or to separate the visits. The completion of the ABC and Change Plan should not occur any later than 10 duty days after the assessment.

3.6.3.1.2. 1 For clients who misuse substances other than alcohol, the required AEM can be modified or replaced as appropriate.

3.6.3.2. DELETED

3.6.4. Education and training programs for officer and enlisted accessions, health care professional course attendees, USAFA cadets, ROTC, and PME students will be conducted IAW DoD Directive 1010.5 "Education and Training in Alcohol and Drug Abuse Prevention" and the responsible agencies course lesson materials.

Table 3.1. Substance Abuse Education.

	If the Individual is.....	then the required training....
1	a military member on his/her first permanent duty assignment	focuses on prevention of substance abuse, standards, desire for peer acceptance, role models, responsible behavior, healthy alternatives, and legal/ administrative consequences of substance abuse. First duty station awareness training will at a minimum be 1 hour in length.
2	a military member in the grade of E1 through E4 on a second or subsequent permanent change of station	will be conducted within 60 days after PCS and shall emphasize standards, healthy lifestyles, responsible behavior and consequences of substance abuse to self and career; training will at a minimum be 30 minutes in length
3	a military member in the grade of E5 through E9 and officers	will be conducted within 60 days after PCS and shall emphasize unique elements of the command's substance abuse prevention and treatment program, local substance abuse threat, military and civilian resources, identifying substance abusers, the referral process, and supervisors' responsibility in the treatment/ process
4	a health care professional, or licensed medical personnel	emphasizes prevention, intervention, identification, diagnosis, and treatment of substance abuse. Training will be provided annually as part of in-service training events.
5	an Airman Leadership School or NCO Academy Student	focuses on responsibilities of leaders in substance abuse prevention, identification and referral of substance abusers, the education and counseling processes, substance abuse treatment programs, intervention, and the impact of substance abuse on the mission. Curriculum developed IAW AFM and AFH 36-2235, and AFH 36-2236
6	an Air University student attending PME Course; Senior NCO Academy (SNCOA); Squadron Officers School (SOS); Air Command and Staff College (ACSC); Air War College (AWC).	focuses on roles and responsibilities of senior leaders in the substance abuse prevention program; effects of substance abuse on mission, morale, readiness, and health and wellness; the education, counseling, referral, and follow-up process; influence of senior leaders attitudes on substance abuse; and the benefits of the service's prevention and treatment programs. Curriculum developed IAW AFM and AFH 36-2235 and AFH 36-2236

7	commander, senior enlisted advisors, first sergeant, and other senior personnel	emphasizes need for active support for substance abuse prevention programs; early intervention of substance abusers; the referral and treatment process; fostering help-seeking behavior; and reducing the stigma associated with substance abuse treatment.
8	a military member or civilian employee involved in a substance abuse related incident	includes information on AF Policy, Understanding the Relationship between Consumption, Metabolism and Intoxication, and Physiological Effects of Alcohol on Brain and Body. These should be considered foundational elements of targeted prevention. Additional components can be added based on the client's needs: for example, Values Clarification, Stress Management, Anger Management, Alcohol and Nutrition, and Cognitive Disputation.

Section 3C—Procedures for Identification and Referral of Suspected or Identified Substance Abusers for ADAPT Services

3.7. Self-Identification. Air Force members with substance abuse problems are encouraged to seek assistance from the unit commander, first sergeant, substance abuse counselor, or a military medical professional. Following the assessment, the ADAPT Program Manager will consult with the Treatment Team, and determine an appropriate clinical course of action.

3.7.1. **Drugs.**

3.7.1.1. An Air Force member may voluntarily disclose evidence of personal drug use or possession to the unit commander, first sergeant, substance abuse evaluator, or a military medical professional.

3.7.1.2. Commanders will grant limited protection for Air Force members who reveal this information with the intention of entering treatment.

3.7.1.3. Commanders may not use voluntary disclosure against a member in an action under the Uniform Code of Military Justice (UCMJ) or when weighing characterization of service in a separation.

3.7.1.4. Disclosure is not voluntary if the Air Force member has previously been:

3.7.1.4.1. Apprehended for drug involvement.

3.7.1.4.2. Placed under investigation for drug abuse. When a member is considered *"placed under investigation"* is determined by the circumstances of each individual case. A member is under investigation, for example, when an entry is made in the Security Forces blotter, when the Security Forces Investigator's log shows an initial case entry, or when the Office of Special Investigations (OSI) opens a case file. A member is also considered under investigation when he or she has been questioned about drug use by investigative authorities or the member's commander, or when an allegation of drug use has been made against the member.

3.7.1.4.3. Ordered to give a urine sample as part of the drug-testing program in which the results are still pending or have been returned as positive.

3.7.1.4.4. Advised of a recommendation for administrative separation for drug abuse.

3.7.1.4.5. Entered treatment for drug abuse.

3.7.1.5. The limited protection under this section for self-identification does not apply to:

3.7.1.5.1. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) has been first introduced by the member.

3.7.1.5.2. Disciplinary or other action based on independently derived evidence (other than the results of commander-directed drug testing), including evidence of continued drug abuse after the member initially entered the treatment program.

3.7.2. **Alcohol.** Commanders must provide sufficient incentive to encourage members to seek help for problems with alcohol without fear of negative consequences.

3.7.2.1. Self identification is reserved for members who are not currently under investigation or pending action as a result of an alcohol-related incident.

3.7.2.2. Self-identified members will enter the ADAPT assessment process and will be held to the same standards as others entering substance abuse education, counseling and treatment programs.

3.8. Commander's Identification and Associated Roles and Responsibilities.

3.8.1. A unit commander shall refer all service members or for assessment when substance use is suspected to be a contributing factor in any incident, e.g., DUI, public intoxication, drunk and disorderly, spouse/child abuse and maltreatment, under-aged drinking, positive drug test, or when notified by medical personnel under **para 3.9.1** - **3.9.3** of this instruction. (Commanders who fail to comply with this requirement place members at increased risk for developing severe substance abuse problems and jeopardize the mission.)

3.8.2. Commander or first sergeant closely examines all DD Form 1569, Incident Complaint Record, for evidence of substance use or abuse.

3.8.3. After coordination with the Staff Judge Advocate, unit commanders will direct drug testing within 24 hours of suspected alcohol related incidents of misconduct, episodes of aberrant or bizarre behavior, or where there is reasonable suspicion of drug use and the member refuses to provide consent for testing. Commanders are also encouraged to ensure Blood Alcohol Tests (BAT) are taken as soon after the incident as possible to determine the level and intensity of alcohol involvement.

3.8.4. The unit commander contacts the installation's ADAPT staff within 7 days of the incident to initiate the assessment process. In incidents of DUI/DWI, the commander will refer the individual to the ADAPT office as soon as possible. The ADAPT staff will complete the initial assessment within 7 days of the commander's suspension of the individuals base driving privileges.

3.8.4.1. If the individual involved in the incident is TDY, the commander at the deployed location determines if the member must return to the permanent duty station. If the member does not return to the permanent duty station, then the ADAPT staff at the TDY location conducts the substance abuse assessment.

3.8.5. Commander refers individuals under investigation for drug abuse for assessment after the commander prefers charges (that is, signs DD Form 458, Charge Sheet). Commanders

who elect not to prefer charges but suspect the individual of drug abuse must refer members for a substance abuse assessment as soon as possible.

3.8.6. The commander provides information to the ADAPT program office to assist in the assessment (e.g., BAT results), including comments on observed performance and behavior to the substance abuse staff before the assessment appointment.

3.8.7. The commander directs the member's immediate supervisor to contact the ADAPT staff before the assessment to provide pertinent information on the patient's duty performance, on and off duty behavior, or other incidents.

3.8.8. The commander tells the member:

3.8.8.1. The reason for the assessment.

3.8.8.2. That the assessment is not punitive in nature.

3.8.8.3. That the member must report in uniform for the substance abuse assessment appointment at the appointed date and time.

3.8.9. The commander ensures the assessment and treatment of personnel is not delayed by ordinary leave or TDYs.

3.8.10. The commander is responsible for all personnel/administrative actions pertaining to patients involved in the ADAPT program, to include assignment availability, promotion eligibility, reenlistment eligibility, PRP, Security Clearance, etc. Application of administrative restrictions should be based on the establishment of a UIF or control roster resulting from the member's unacceptable behavior and not solely based on their involvement in the ADAPT program.

3.8.11. The Commander will actively participate on the Treatment Team (TT) by providing input to treatment decisions. Command involvement is critical to a comprehensive substance abuse treatment program, particularly in the prevention and early intervention stages, as well as during aftercare and follow-up activities. The commander shall also provide command authority to implement the treatment plan when the member does not voluntarily comply with the TT's decisions.

3.9. Medical Care Referrals.

3.9.1. Medical personnel must notify the unit commander and the ADAPTPM when a member:

3.9.1.1. Is observed, identified, or suspected to be under the influence of drugs or alcohol.

3.9.1.2. Receives treatment for an injury or illness that may be the result of SA.

3.9.1.3. Is suspected of abusing substances.

3.9.1.4. Is admitted as a patient for alcohol or drug detoxification.

Section 3D—Assessing Members for Substance Abuse

3.10. Purpose. The central purpose of the SA assessment is to determine the patient's need for treatment and level of care required.

3.10.1. **ADAPT Staff Members:**

3.10.1.1. Schedule all assessment appointments upon notification of the referral. Referral information will be documented on the SF 600, Chronological Record of Medical Care.

3.10.1.2. Conduct the substance abuse assessment within 7 duty days of notification.

3.10.1.3. Before the assessment appointment, explain to the patient's supervisor:

3.10.1.3.1. The requirement that the supervisor provide information on the patient's duty performance and on- and off-duty behavior.

3.10.1.3.2. The current status and requirements of the member.

3.10.1.3.3. Limits of confidentiality.

3.10.1.3.4. The counselor's responsibilities.

3.10.1.3.5. The assessment process.

3.10.1.4. Before eliciting information from the patient, brief the patient on:

3.10.1.4.1. Stipulations of self-identification, if applicable.

3.10.1.4.2. Limits of confidentiality.

3.10.1.4.3. Privacy Act provisions.

3.10.1.4.4. Overview of ADAPT to include program rules and patient rights and responsibilities.

3.10.1.4.5. The mental health technician/drug/alcohol counselor’s responsibilities.

3.10.1.4.6. The purpose, access, and disposition of mental health records.

3.10.1.4.7. The option and consequences of refusing treatment.

3.10.1.5. During the initial assessment, brief patients being considered or processed for separation on their entitlement to substance abuse treatment with the Veterans Administration (VA).

3.10.1.6. Include in the assessment, as appropriate:

3.10.1.6.1. Referral information.

3.10.1.6.2. Biopsychosocial history and current status.

3.10.1.6.3. Occupational, social, financial, and legal history.

3.10.1.6.4. History of substance use or abuse.

3.10.1.6.5. Medical problems.

3.10.1.6.6. Mental status exam.

3.10.1.6.7. A preliminary diagnostic impression.

3.10.1.6.8. Substance abuse treatment recommendation.

3.10.1.7. If the patient is TDY or on leave, contact the member’s home base and inform them of the substance abuse-related incident and the status of the assessment process.

3.10.2. ADAPT Program Managers:

3.10.2.1. Provide supervision for Certified Substance Abuse Counselors IAW AFI 44-119 or other Air Force policy.

3.10.2.2. Conduct required reviews of the patient's medical records and all documentation provided by the substance abuse staff on a priority basis.

3.10.2.3. Observe the patient's general physical and mental condition during the assessment. Refers for additional medical, psychiatric, or laboratory examinations as needed.

3.10.2.4. Chair Treatment Team (TT) Meetings.

3.10.2.5. Refer military members identified for illicit or illegal drug abuse or members diagnosed with Alcohol Abuse or Alcohol Dependence for human immunodeficiency virus (HIV) testing.

3.10.2.6. Serves as a member of the Deployment Availability Working Group (DAWG) or delegates another privileged mental health provider to serve as a member of the DAWG and ensures that provider knows the status of all ADAPT patients.

3.10.3. Certified Alcohol and Drug Abuse Counselor (CADAC):

3.10.3.1. Background. Mental health technicians serve in clinical roles as CADACs in the ADAPT Program. They provide services in the following 12 core functions outlined by the International Certification and Reciprocity Consortium (ICRC): screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, report and record keeping, and consultation. NOTE: The Air Force Substance Abuse Counselor Certification program issues the certification and has the authority to revoke certification for cause.

3.10.3.2. Education and Certification Requirements:

3.10.3.2.1. Have a minimum of 270 hours didactic instruction and 6,000 hours within the 12 core functions of substance abuse counseling, 300 of which must be accomplished via direct supervision by another fully qualified CADAC or privileged mental health provider.

3.10.3.2.2. Have a signed agreement to practice under strict USAF ethical guidelines. NOTE: Ethical guidelines are state/board specific.

3.10.3.2.3. Pass a recognized written examination administered by the USAF.

3.10.3.2.4. Obtain nationally recognized certification from the ICRC.

3.10.3.2.5. Recertify every 3 years by obtaining a minimum of 60 hours of continuing professional education within the behavioral sciences, as outlined by the AF Substance Abuse Counselor Certifying Handbook.

3.10.3.3. Scope of Practice/Supervision. Certified Alcohol and Drug Abuse Counselors perform the 12 core functions independently as directed by the ADAPT program manager. Provide treatment planning, crisis intervention, and group treatment under the supervision of a privileged mental health provider. For initial assessment, development of or changing a treatment plan, and crisis intervention, privileged mental health providers

are responsible for "eyes on" supervision of CADACs. This is defined as direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation note made in the chart by the CADAC before the patient departs the appointment. Supervising privileged mental health providers must document supervision in the medical record following each episode supervised.

3.10.3.3.1. The ADAPT program manager is responsible for the clinical practice of CADACs and is familiar with the training needs of CADACs working in other areas of the mental health career field. Therefore, the ADAPT program manager maintains training records of all CADACs working in substance abuse. To ensure ongoing training and competency assessment for CADACs, the ADAPT program manager, or designee, must observe and assess the CADAC while providing individual or group treatment, at least two times per month for a total of at least two hours monthly. Competency assessments will focus on direct client contact within the 12 core functions of substance abuse counseling, and will be documented in the CADAC's training record. In fulfilling this requirement, the observer and counselor will abide by strict ethical standards.

3.10.3.3.2. Non-certified 3-level mental health technicians who are in training may conduct the 12 core functions only when supervised by a CADAC or privileged mental health provider. They will require direct supervision during the entire patient contact. At the discretion of the ADAPTPM following a period of direct observation and evaluation, non-certified 5-level and 7-level mental health technicians may conduct the 12 core functions without direct supervision. A fully qualified CADAC or as required by paragraph 3.10.3.3. a privileged provider is responsible for eyes-on supervision before the patient departs the appointment. Eyes-on supervision is defined as direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment. The CADAC or privileged mental health provider who performed this supervision must cosign the note in the patient record.

3.11. Using Assessment Results.

3.11.1. Information gathered during the assessment will form the basis for patient diagnosis, treatment planning, and delivery of substance abuse services.

3.11.2. Except in cases of self-identification, information the patient provides in response to assessment questions may be used in a court-martial and to characterize service at the time of discharge. Such evidence may be introduced for other administrative purposes or for impeachment or rebuttal purposes in any proceeding in which the patient introduced evidence of substance abuse (or lack thereof).

3.11.3. Before adjudication, the ADAPT provider will provide assessment results on individuals who are charged with intoxicated driving to the patient's commander.

Section 3E—Treatment Team (TT)

3.12. General. The primary objective of the Treatment Team is to guide the clinical course of treatment of the patient after examining all the facts.

3.13. Treatment Team Composition Roles, and Functions.

3.13.1. Membership of TT:

3.13.1.1. Commander and/or first sergeant.

3.13.1.2. Patient's immediate supervisor.

3.13.1.3. ADAPTPM, or a privileged provider with administrative oversight responsibility for the ADAPT program. The ADAPTPM chairs the TT and determines the clinical course of treatment for patients in the ADAPT Program.

3.13.1.4. Certified substance abuse counselor and/or provider.

3.13.1.5. Medical consultant(s) as needed.

3.13.1.6. Any therapist concurrently involved in the care of the individual.

3.13.1.7. Other individuals as deemed necessary.

3.13.1.8. The patient unless deemed clinically inappropriate. In this case, the patient will be briefed on the treatment decisions of the TT.

3.13.2. If the patient is on flight status, a flight surgeon will be included in the TT meeting.

3.13.3. Commander or first sergeant, and supervisor involvement in the TT at key points in the patient's treatment and recovery is important. The commander or first sergeant, and supervisor must be involved at program entry, termination, and any time there are significant treatment difficulties with the patient. ADAPT personnel must brief commanders on patient progress at least quarterly--telephonically, individually, or within the TT.

3.13.4. Treatment Planning. The primary purpose of the treatment plan is to establish the frame work for the patient's treatment and recovery.

3.13.4.1. The treatment plan documents the level and intensity of care, incorporates issues, problem areas, life skill deficits, and goals identified during the biopsychosocial assessment, and identifies appropriate treatment resources to be utilized during the patients course of treatment.

3.13.4.2. The treatment plan will be comprehensive, individual specific, and stated in behavioral terms.

3.13.4.3. Treatment plans will be reviewed on a regular basis, at least quarterly, to ensure that the plan reflects status of the patient's progress toward effective substance abuse recovery and stabilization of other identified clinical issues.

3.13.5. The ADAPTPM, in consultation with the TT, makes a treatment decision within 15 duty days of the referral to the ADAPT Office. Reasons for delays must be documented in the outpatient mental health record on SF 600 and conveyed to the commander.

3.13.6. Documenting the TT. TT activity will be documented completely in the mental health record, and a brief overview of the TT activity will be placed in the outpatient medical record on SF 600.

Section 3F—Substance Abuse Treatment

3.14. DELETED

3.14.1. DELETED

3.14.1.1. DELETED

3.14.2. DELETED

3.15. Clinical Services.

3.15.1. Patients meeting the DSM IV diagnostic criteria for alcohol abuse or alcohol dependence will be entered into substance abuse treatment with the level and intensity of care determined by the ADAPTPM using current American Society of Addiction Medicine (ASAM) criteria.

3.15.2. A continuum of substance abuse care that is compatible with the patient placement criteria of the American Society of Addiction Medicine shall be provided. ASAM criteria reflect the philosophy of placing patients in the least intensive/restrictive treatment environment, appropriate to their therapeutic needs. Variable lengths of stay/duration of treatment shall be provided within a variety of treatment settings. The treatment program will reflect a multi-disciplinary approach to assist the patient to achieve full recovery, free of the negative effect of the substance abuse.

3.15.2.1. Individuals being processed for separation will be provided appropriate medical care prior to separation. Separation action will not be postponed because of a members participation in the ADAPT Program.

3.15.3. Program requirements will be individually tailored to meet the needs of the patient and include awareness education on the biopsychosocial concepts of addiction, defense mechanisms, self esteem/self concepts, family dynamics, relapse prevention, physical effects of substance abuse, stress management, anger management/assertiveness, goals and recovery plans, and other subject matter that TT deems necessary. Family involvement is strongly encouraged.

3.15.3.1. Individuals diagnosed with alcohol abuse or alcohol dependence will refrain from the use of alcohol during the initial phase of treatment, and will be strongly encouraged to continue to abstain during aftercare. Total abstinence is a critical treatment goal; however, because of the nature of alcoholism, relapses into drinking behavior are not uncommon and should be anticipated. A relapse by itself is not sufficient reason for program failure; however, relapses must be considered a significant threat to the patient's treatment and dealt with appropriately.

3.15.3.2. Involvement in self-help recovery groups (i.e. 12-step, rational recovery) is encouraged as an adjunct to treatment. The frequency of attendance is determined by the TT with the patient. The TT will encourage the patient to attend smoke-free recovery groups.

3.15.4. Patients will adhere to the treatment plan developed by the TT.

3.15.5. ADAPT staff will contact the Residential Rehabilitation Program or Nonresidential Rehabilitation Program intake coordinator requesting admission of the patient.

3.15.6. DELETED

3.15.7. Detoxification Prior to Treatment.

3.15.7.1. Patients being referred for in-patient treatment will be assessed to determine the level of detoxification services required. To the greatest extent possible, patient detoxification will be managed on an outpatient basis prior to inpatient treatment.

3.15.7.2. Patients assessed as requiring medically managed detoxification (in-patient) will be entered into an appropriate medical facility.

3.15.7.3. All patients utilizing aeroevacuation services must have 72 hours of monitored abstinence (inpatient or outpatient) prior to departure.

3.15.7.4. Local patients referred to a partial (day treatment) or inpatient substance abuse service may begin treatment immediately, if the history, physical examination, and other documentation indicates the patient can safely begin treatment. If, however, the patient experiences symptoms of apparent withdrawal, he or she will be re-assessed and detoxification protocol initiated.

3.15.8. Patients returning from the SARC will have a TT meeting convened within 10 duty days of return to assess the patient's progress during in-patient treatment and design a treatment plan for aftercare.

3.15.9. Use of Disulfiram (Antabuse), naltraxone, etc., in treatment programs will be strictly monitored by a physician or psychiatrist and the SARC director.

3.15.10. Outcome Measurements. The local ADAPT program will develop procedures to evaluate the effectiveness of its program. Procedures should include determining accuracy of patient assessments, appropriateness of treatment plans, proportion of patients successfully completing the treatment program, unforeseen complications in treatment process, and access time to assessment and treatment. Procedures should also include assessment of drinking behavior and duty performance at the 3, 6, and 12 month post discharge from intensive outpatient, partial hospitalization, variable length of stay, or in-patient treatment programs. Prevention services should assess the proportion of the target population provided substance abuse preventive education, range of preventive education offered, attendee satisfaction with the program, and appropriate performance/outcome measures.

3.15.11. **Clinical Services for Civilian Employees.**

3.15.11.1. To ensure maximum workplace productivity through an alcohol misuse and drug-free workforce, National Security Personnel System (NSPS), General Schedule (GS), and non-appropriated funds (NAF) employees may be seen for an initial ADAPT evaluation if they screen positive for drugs or, have on base or on duty substance related misconduct.

3.15.11.1.1. Early intervention is essential to the effective operation of this program and the successful rehabilitation of civilian employees. Therefore, supervisors must be alert to behaviors that could indicate a substance abuse problem (prior to the occurrence of alcohol-related misconduct or MRO-verified drug test positive) and advise civilian employees they may voluntarily seek assessment and treatment referral services.

3.15.11.2. **Referral Process.**

3.15.11.2.1. Supervisors will advise civilian employees on the availability of services when there is any reason to believe that there may be a substance abuse problem.

This advice does not require an employee to admit to any problem, but merely offers appropriate assessment and referral to counseling and rehabilitation services.

3.15.11.2.1.1. The Drug Demand Reduction Program Manager and/or ADAPT program staff provides appropriate guidance to supervisors on referral for the evaluation. Supervisors must direct civilian employees to report for initial assessment and referral for treatment any time drug use is verified by the MRO or there is alcohol-related misconduct and follow up with civilian employees to ensure completion. Supervisors will notify the commander when an employee refuses to comply with a mandatory referral for counseling.

3.15.11.2.2. When requested by an employee, a rehabilitation team will convene to provide advice and assistance to supervisors and/or employees to facilitate counseling and/or rehabilitation efforts. During the course of counseling/rehabilitation, underlying issues may be identified, e.g., financial or family conflicts as well as problems in the work setting. Although the employee is ultimately responsible for his/her rehabilitation, the team may review the facts and make recommendations to the supervisor and/or employee. Such recommendations may include additional referrals, e.g., financial or family counseling, job training, work scheduling, reassignment and/or retirement options. When the employee has consented, in writing, to the release of confidential treatment information, the supervisor may request the team advice on the appropriateness of a treatment plan as well as whether the employee is making reasonable progress.

3.15.11.2.3. Regardless of the referral and/or treatment options chosen, the employee remains solely responsible for his or her behavior. Assertions that the counselor failed to consider one or more of the above factors in making a referral will not constitute either an excuse for continuing to abuse alcohol or a defense against disciplinary action if the employee is identified for subsequent substance abuse.

3.15.11.3. **Employee Counseling and Assistance.**

3.15.11.3.1. EAP contractor personnel or ADAPT staff provide and document initial substance abuse evaluations of all referred or self-identified civilian employees. Civilian employees will be advised of options for substance abuse counseling and treatment through referral agencies. To ensure that appropriate referrals are made, EAP and ADAPT personnel should consider the nature and severity of the problem, location of the treatment, cost of the treatment, intensity of the treatment environment, availability of inpatient/outpatient care, and other special needs, such as transportation, family issues, and child care. Documentation of the initial assessment must be IAW AFI 41-210, *Patient Administrative Functions.*

3.15.11.3.1.1. EAP and ADAPT personnel ensure medical and MH records of civilian personnel referred for assessment and/or treatment are appropriately updated to include: referral data, patient confidentiality and release of information, options for accepting or refusing treatment, assessment data, and appropriate treatment planning, case management, and/or clinical services provided.

3.15.11.3.1.2. If seen in ADAPT, information in the medical record should

include a thorough initial note outlining the results of assessment, and employee consent to release/diagnostic procedures. Subsequent contacts should also be reflected in brief notes in medical records indicating the nature and outcome of services provided. Changes in status, diagnosis, or treatment plan; initiation or change in medication; or termination of services should be thoroughly documented in the medical record.

3.15.11.3.1.3. Referral Options. Civilian employees may use a wide variety of treatment options to include: community-based treatment programs (for uninsured or underinsured individuals), private providers covered by the employee's health insurance, or military benefits, if applicable. Military-based counseling and/or treatment services may be provided on a space available, reimbursable basis depending on the eligibility status of the employee and IAW HHS/TRICARE guidelines outlined in AFH 41-11, Section E, Health Care for Eligible Civilians and Special Categories of Beneficiaries and Their Family Members. Civilian employees are responsible for payment for these services which is generally accomplished by submitting claims to their Federal Health Benefits System health insurance provider.

3.15.11.4. **Counselor Responsibilities.**

3.15.11.4.1. The ADAPT or contract counselor counsels the employee on the scope of services available for counseling, assessment, and referral.

3.15.11.4.1.1. For the mandatory initial assessment appointment, the employee will be advised by way of documented initial informed consent that their supervisor will be notified that the employee attended the interview and the reporting and departing time of the employee.

3.15.11.4.1.2. The employee is advised of what information will be disclosed to the supervisor at the beginning of the initial interview. At that time the counselor also tells the employee that strict rules govern the disclosure of substance abuse counseling information and how those rules apply to the position the employee holds.

3.15.11.4.1.2.1. The employee will be provided a copy of the form, Consent for Release of Patient Information During or After Treatment or Rehabilitation (Attachment 6). The counselor will explain that the employee is not required to sign the release, but doing so will allow for the treatment provider to communicate progress back to the supervisor and the Civilian Rehabilitation Team. The information may then be considered in deciding on the appropriateness of various actions including discipline and continued assignments to testing designated or other sensitive positions. Release of this information also furthers the rehabilitation process by ensuring that the supervisor is involved in the process and serves to justify the use of sick leave for treatment and counseling.

3.15.11.4.2. ADAPT personnel will advise civilian employees that if they choose to use ADAPT services, a MH record and a medical record will be established to ensure

professional accountability and to facilitate on-going assessment of the quality, appropriateness, and progress of rehabilitation.

3.15.11.4.3. Regardless of options selected, civilian employees will be encouraged to authorize the release of information to appropriate management officials to assist in evaluation of their treatment. Civilian employees will be advised that release of such information is not mandatory.

3.16. Completing the Program.

3.16.1. Successful Completion. Patients will not be considered to have successfully completed treatment until they meet the DSM criteria for early full remission. The TT determines, based on DSM criteria, patient progress towards agreed upon goals and/or issues as stated in the treatment plan, when the patient is effectively in recovery and no longer requires program resources.

3.16.2. Failing the Program. The TT determines a patient to have failed the program based on a demonstrated pattern of unacceptable behavior, inability or unwillingness to comply with their treatment plan, or involvement in alcohol and/or drug related incidents after receiving initial treatment. The determination that a patient has failed treatment is based on the patient's repeated failure to meet and maintain Air Force standards (behavior), rather than solely on the use of alcohol. Individuals who have been determined as failing the ADAPT program shall be considered for administrative separation by their commander IAW AFI 36-3207, or AFI 36-3208.

3.17. Continuity of Care Following Intensive Outpatient, Partial or Inpatient Treatment Completion.

3.17.1. The treatment team will meet within 10 days of a patient's completion of an intensive outpatient, partial day treatment, or inpatient treatment program to review progress and recommend a course of treatment for aftercare. Decisions regarding aftercare services will be based on a current assessment of status and will include establishment of an aftercare treatment plan identifying specific goals, interventions, and means to assess interventions.

3.17.2. Patients' progress will be monitored by the ADAPT staff at least monthly while the patient is in aftercare.

3.17.3. Determinations about a patient's availability for PCS or TDYs will be coordinated through the TT during the patient's course of treatment. Generally, patients diagnosed with alcohol abuse or alcohol dependence are restricted from worldwide duty for their first six months of treatment.

3.17.4. Patients on mobility status who are in aftercare should be carefully assessed by the TT. When appropriate, the TT should recommend in writing that the individual be temporarily removed from the mobility position during the period of aftercare.

3.17.4.1. Patients making minimal or unsatisfactory progress in recovery should not be allowed to proceed on TDYs or a PCS, except for mandatory PCS moves. The TT will recommend to the commander that the individual not be released. At times, exceptional circumstances may warrant other approaches.

3.17.4.2. When patients PCS, the ADAPT staff will forward one copy of the patient's outpatient mental health record to the gaining base's outpatient mental health clinic to ensure continuity of care is maintained.

3.17.5. Following intensive outpatient, partial or inpatient treatment, the SARC Program Director will provide a treatment summary, to include aftercare recommendations, to the ADAPTPM and commander.

3.17.6. Decisions regarding access to classified material, security clearances, PRP, flying status will be determined by governing instructions for each program.

3.18. The Use Of The Preventive Individual Medical Readiness (PIMR) System To Monitor Patients in Treatment.

3.18.1. When diagnosed with substance abuse or dependence and entered into the ADAPT Program, the ADAPTPM will enter the demographic data, annotate that the member is not qualified for World Wide Duty, check the Mobility Restriction box, and enter a release date on the AF Form 469 in PIMR. Only specific limitations will be entered. Diagnoses will not be recorded on the comment or limitation section of this form. After electronic signature, the form will be automatically forwarded to Force Health Management (FHM) which will assess the form, determine if the condition will require a code 31, 37, or 81, (ADAPT patients will normally be code 31) annotate it appropriately, and forward it to the Profile Officer. The Profile Officer will validate by electronic signature, and the form will be automatically returned to FHM. It is then forwarded electronically to the member's unit commander for concurrence/non-concurrence. The commander or designated representative will issue the form to the member.

3.18.2. The ADAPTPM or CADAC will monitor patient status and progress in treatment to determine the appropriateness for continuation or termination of the Duty Limiting Condition (DLC) at each visit and document. At least monthly, the ADAPTPM will review status with the Deployment Availability Working Group (DAWG). Guidance concerning the use of Duty Limiting Conditions can be found in AFI 10-203, *Duty Limiting Conditions*, 25 Oct 2007, and AFI 48-123, *Medical Examinations and Standards*, 24 Sep 2009.

3.18.3. As a member of the DAWG, the ADAPTPM or another privileged mental health provider will review all patients identified as having a substance use related deployment-limiting medical condition.

3.18.4. DELETED

CHARLES H. ROADMAN II, Lt General, USAF
MC Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

10. U.S.C. 8013,

42. U.S.C. 290 dd2,

Executive Order 9397,

Executive Order 11478,

DoD 1010.4, *Alcohol and Drug Abuse by DoD Personnel*, 25 Aug 80,

DoD Instruction 1010.5, *Education and Training In Alcohol and Drug Abuse Prevention*, 5 Dec 80,

DoD Instruction 1010.6, *Rehabilitation and Referral Services for Alcohol and Drug Abusers*, 13 Mar 85,

DoD Directive 1010.7, *Drunk and Drugged Driving by DoD Personnel*, August 10, 1983, with Changes 1 and 2;

DoD Directive 1010.10, *Health Promotions*, 11 Mar 86, With Change 1,

ASD(HA) Policy OSD(HA) *Memorandum on TRICARE Substance Abuse Treatment*, 13 Feb 97,

AFI 31-501, *Personnel Security Program Management*,

AFI 36-2104, *Personal Reliability Program (PRP)*,

AFI 36-2907, *Unfavorable Information Files (UIF)*,

AFI 36-2910, *Line of Duty (Misconduct) Determinations*,

AFI 44-119, *Medical Service Clinical Quality Management*,

AFI 48-123, *Medical Examinations and Standards.*

Abbreviations and Acronyms

AA—Alcoholic Anonymous

ADAPT—Alcohol & Drug Abuse Prevention & Treatment

AFPD—Air Force Policy Directive

ASAM—American Society of Addiction Medicine

BAT—Blood Alcohol Test

DRU—Direct Reporting Unit

DSM—Diagnostic Statistical Manual

DUI—Driving Under the Influence

DWI—Driving While Intoxicated

FOA—Field Operating Agency

FSC—Family Support Center

GSU—Geographically Separated Unit

IAW—In accordance with

MAJCOM—Major Command

NCO—Noncommissioned Officer

NGB—National Guard Bureau

OSI—Office of Special Investigations

PCS—Permanent Change of Station

SA—Substance Abuse

SARC—Substance Abuse Recovery Center

SG—Surgeon General

SOAP—Subjective, Objective, Assessment, Plan (case note format)

TT—Treatment Team

TTM—Treatment Team Meeting

TDY—Temporary Duty Assignment

VA—Veterans Administration

Terms

Abstinence—The practice of refraining from the consumption or use of alcohol and other intoxicating substances.

Alcohol Abuse—Any substandard behavior or performance in which the consumption of alcohol is a primary contributing factor. This definition should not be confused with the diagnosis of Alcohol Abuse as outlined in the DSM.

Alcoholics Anonymous—(AA)--A fellowship of men and women who share with each other their experience, strength, and hope that they may solve their common problem and help others to recover from alcoholism.

Alcoholism—A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by:

Impaired control over drinking.

Preoccupation with the drug alcohol.

Use of alcohol despite adverse consequences.

Distortions in thinking, most notably denial.

Each of these symptoms may be continuous or periodic (National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine, 1992) and includes the diagnoses of alcohol abuse and alcohol dependence.

Alcohol—Related Misconduct—This type of conduct includes driving while intoxicated, public incidents of intoxication and misconduct, under-aged drinking, or similar offenses and is a breach of discipline

Clinical Treatment—Services designed for the treatment of patients diagnosed with alcohol abuse or alcohol dependence. These services include a wide range of programs including intensive outpatient treatment, partial hospitalization, variable length of stay programs, and inpatient hospitalization.

Demand Reduction Program Manager—Person responsible for oversight of civilian and military drug testing programs.

Detoxification—A planned management of alcohol and drug withdrawal. Clients usually undergo medical detoxification as inpatients. Detoxification includes keeping alcohol and other drugs of abuse away from the individual and providing indicated medical and psychological support.

Drug—Any controlled substance included in Schedules I, II, III, IV, and V in 21 U.S.C. 812, including anabolic or androngenic steroids, or any intoxicating substance other than alcohol, that is inhaled, injected, consumed, or introduced into the body in any manner to alter mood or function.

Drug Abuse—The illegal, wrongful, or improper use, possession, sale, transfer, or introduction onto a military installation of any drug defined in this instruction.

Intervention—The process of helping the member recognize at the earliest possible moment that he or she needs treatment for self-destructive drinking or drug abuse. This professionally structured event includes significant others in the member's life.

Intoxication—Maladaptive behavior, such as aggressiveness, impaired judgment, and manifestation of impaired social or occupational functioning, because of recent ingestion, inhalation, or injection of any substance into the body. Characteristic physiological and psychological signs include flushed face, slurred speech, unsteady gait, Nystagmus, lack of coordination, impaired attention, irritability, euphoria, or depression.

Privileged Provider—Military (Active or Reserve component) and civilian personnel (civil service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimes within the scope of his or her license, certification, or registration.

Privileges—Permission to provide medical and other patient care services in the granting institution within defined limits based on the individual's education, professional license, experience, competence, ability, health, and judgment.

Relapse—A return to drinking or drug use after a period of abstinence

Substance—Alcohol and other mind or mood altering drugs, including illicit drugs, prescribed mediations, and over-the-counter medications.

Substance Abuse—The use of any illicit drug or the misuse of any prescribed medication or the abuse of alcohol. "Abuse" refers to any pattern of unconventional misuse of any substance for non-medical purposes that produces a known health risk or constitutes a danger to self or others.

Substance Abuse—Assessment Process—The assessment and decision-making process to determine the nature and extent of a member's substance abuse involvement and the appropriate intervention.

Tolerance—The condition in which a person needs increased amounts of a substance to achieve the desired effect or experiences a markedly diminished effect with regular use of same dose.

Withdrawal—A substance-specific syndrome that occurs when a person ceases to use or reduces ingestion of a substance that the person previously used regularly to induce a state of intoxication.

Attachment 2

IC 99-1 TO AFI 44-121, ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM

1 JANUARY 1999

SUMMARY OF REVISIONS

This interim change (IC) 99-1 defines minimum required base ADAPT treatment services, prohibits the ingestion of hemp oil or products made with hemp seed oil, defines provider flexibility in referring individuals to the six-hour awareness education program, clarifies requirements for aftercare services, and changes requirements for administration of temporary profiles. This IC applies to all active duty Air Force members, members of the Air Force Reserve and Air National Guard. Failure to observe the prohibition found in this IC is a violation of Article 92, Uniform Code of Military Justice (UCMJ).

1.8.2. Coordinates on-base resources to provide effective prevention, education, identification, assessment, and treatment programs. On-base services must include early intervention (Level 0.5) and outpatient programs (Level I) as defined in the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders. Programs must specifically address intoxicated driving IAW DoD Directive 1010.7, Drunk and Drugged Driving by DoD Personnel, August 10, 1983.

3.5.5. Studies have shown that products made with hemp seed oil may contain varying levels of tetrahydrocannabinol (THC), an active ingredient of marijuana which is detectable under the Air Force Drug Testing Program. In order to ensure military readiness, the ingestion of hemp seed oil or products made with hemp seed oil is prohibited. Failure to comply with the prohibition on the ingestion of hemp seed oil or products made with hemp seed oil is a violation of Article 92, UCMJ.

3.14.1. All patients referred for substance abuse assessment who do not meet diagnostic criteria for alcohol abuse or alcohol dependence will be provided a minimum of 6 hours of awareness education. The only exceptions to this requirement are in instances where alcohol was not a factor in the referral or when the provider determines awareness education is clearly not warranted. Additional counseling addressing biopsychosocial issues identified in the assessment may be prescribed. Length of involvement will be determined based on the patient's presenting problems and agreed upon treatment or behavioral contract.

3.17.1. The treatment team will meet within 10 days of a patient's completion of an intensive outpatient, partial day treatment, or inpatient treatment program to review progress and recommend a course of treatment for aftercare. Decisions regarding aftercare services will be based on a current assessment of status and will include establishment of an aftercare treatment plan identifying specific goals, interventions, and means to assess interventions.

3.18.1. All patients diagnosed with substance abuse or dependence and entered into the

ADAPT Program will be placed on an S4T profile indicating the patient is not worldwide qualified.

3.18.2. The ADAPT PM will continuously monitor patient status and progress in treatment to determine the appropriateness for continuation or termination of the profile.

Attachment 3

IC 99-2 TO AFI 44-121, ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM

22 JANUARY 1999

SUMMARY OF REVISIONS

This interim change (IC) 99-2 changes the effective date of the information contained in IC 99-1 to
22 January 1999, the actual date approval was granted by the Surgeon General.

Attachment 4

IC 2001-1 TO AFI 44-121, ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM

1 JANUARY 2001

SUMMARY OF REVISIONS

This interim change (IC) 2001-1 prohibits the ingestion of products containing or derived from hemp seeds or hemp seed oil. This IC applies to all active duty Air Force members, members of the Air Force Reserve and Air National Guard. Failure to observe the prohibition found in this IC is a violation of Article 92, Uniformed Code of Military Justice (UCMJ). A bar (|) indicates revision from the previous edition. See the last attachment for the complete IC.

3.5.5. Studies have shown that products made with hemp seed and hemp seed oil may contain varying levels of tetrahydrocannabinol (THC), an active ingredient of marijuana which is detectable under the Air Force Drug Testing Program. In order to ensure military readiness, the ingestion of products containing or products derived from hemp seed or hemp seed oil is prohibited. Failure to comply with the prohibition on the ingestion of products containing or products derived from hemp seed or hemp seed oil is a violation of Article 92, UCMJ.

Attachment 5

IC 2001-1 TO AFI 44-121, ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT) PROGRAM

26 SEPTEMBER 2001

SUMMARY OF REVISIONS

This revision incorporates Interim Change IC 2001-1. This interim change (IC) 2001-1 clarifies requirements for referral to the ADAPT program by commanders in instances in which an individual is suspected of involvement in drug abuse. A "|" indicates revised material since the last edition.

3.8.5. Commander refers individuals under investigation for drug abuse for assessment after the commander prefers charges (that is, signs DD Form 458, Charge Sheet). Commanders who elect not to prefer charges but suspect the individual of drug abuse must refer members for a substance abuse assessment as soon as possible.

Attachment 6

CONSENT FOR RELEASE OF PATIENT INFORMATION DURING OR AFTER TREATMENT OR REHABILITATION

I, _____, hereby consent to the disclosure of
(Employee/Patient Name)

information concerning my progress in terminating illicit drug use. I authorize the

_____
(Treatment/Rehabilitation Program)

to disclose that information to the following individuals:

The Alcohol and Drug Abuse Prevention and Treatment Program Manager (ADAPTPM) or the Employee Assistance Program Counselor,

(Name and location: _____);

My supervisor (Name :_____);

and the Human Resources Representative (Name:_____)

for monitoring under Executive Order (EO) 12564, which sets forth the objective of achieving a drug-free Federal workplace.

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, and that it will expire without express revocation upon

_____.
(Date, Event, and/or Condition)

This consent to disclose the above described treatment records for the purpose set out above was voluntary and not subject to coercion.

_____ _____
(Signature of Employee/Patient) (Date)

CLAUSE FOR USE IF EMPLOYEE IS A MINOR OR LEGALLY INCOMPETENT

I, _____, the (parent/legal guardian or personal legal
(Name)

representative) of the above named employee/patient, hereby consent to the aforementioned release of information on his/her behalf.

_____ _____
(Signature of parent/legal guardian or personal legal representative) (Date)